SECTION 8

Post-acute care

Skilled nursing facilities
Home health agencies
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1. Number of post-acute care providers increased or remained stable in 2011

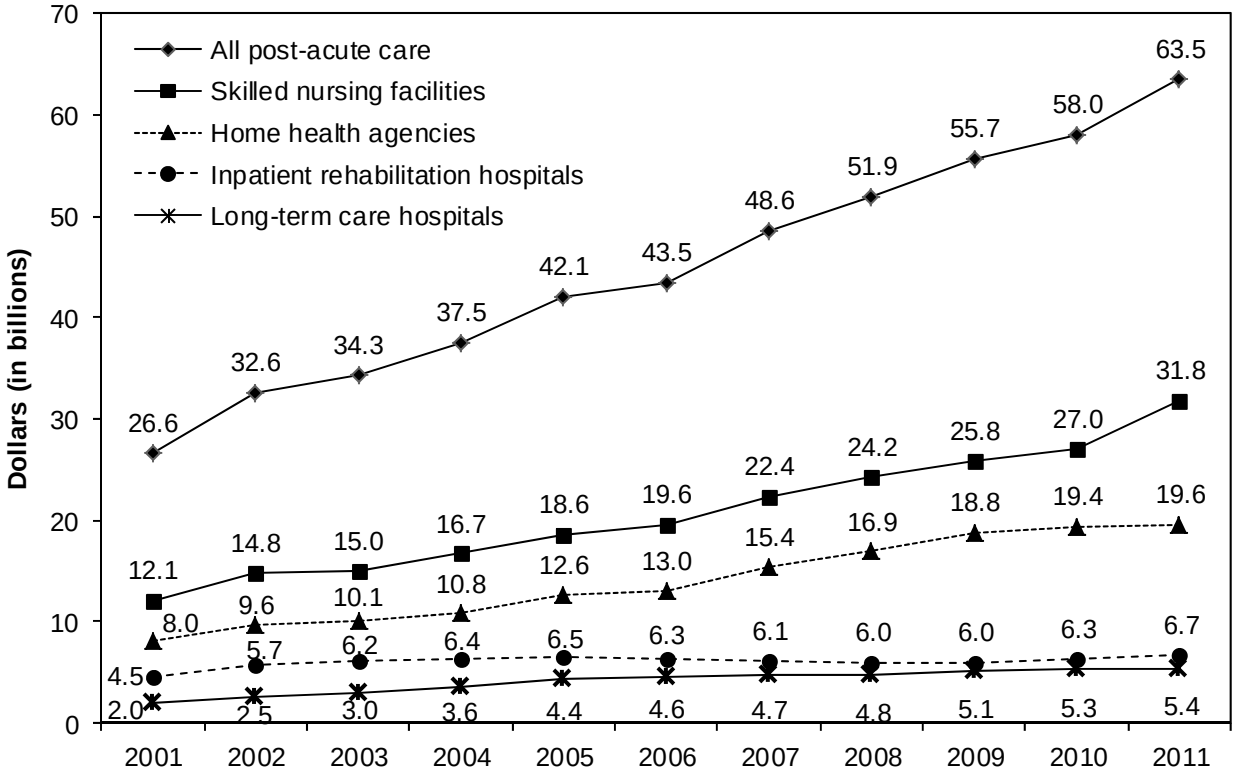
	2003	2004	2005	2006	2007	2008	2009	2010	2011	Average annual percent change 2003-2011	Percent change 2010–2011
Home health agencies	7,342	7,804	8,314	8,955	9,404	10,040	10,961	11,654	12,026	6.4%	3.2%
Inpatient rehabilitation facilities	1,207	1,221	1,235	1,225	1,202	1,202	1,196	1,179	1,165	–0.4	–1.2
Long-term care hospitals	334	366	392	398	406	425	435	437	436	3.4	–0.2
Skilled nursing facilities	15,144	15,156	15,185	15,178	15,207	15,190	15,190	15,207	15,161	0.1	–0.3

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification's Providing Data Quickly system for 2003–2011 (home health agencies, long-term care hospitals, and skilled nursing facilities) and CMS Provider of Service data (inpatient rehabilitation facilities).

- The number of home health agencies has increased substantially since 2003. The number of agencies increased by over 350 in 2011. The growth in new agencies is concentrated in a few areas of the country.
- The number of inpatient rehabilitation facilities (rehabilitation hospitals and rehabilitation units) declined slightly in 2011.
- In spite of a moratorium on new long-term care hospitals (LTCHs) beginning in October 2007, the number of these facilities continued to grow through 2010. The number of LTCHs declined by one facility in 2011.
- The total number of skilled nursing facilities has remained about the same since 2003, but the mix of facilities continues to shift from hospital-based to freestanding facilities. Hospital-based facilities make up 6 percent of all facilities, down from 9 percent in 2003.

Chart 8-2. Medicare's spending on home health care and skilled nursing facilities fueled growth in post-acute care expenditures



Note: These numbers are program spending only and do not include beneficiary copayments.

Source: CMS Office of the Actuary.

- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part due to expanded enrollment in managed care, whose spending is not included in this chart.
- Despite the slower growth, spending on all post-acute care still grew close to 9 percent between 2010 and 2011, fueled primarily by increases in skilled nursing facility expenditures.
- Fee spending on inpatient rehabilitation hospitals has declined since 2005 and 2008, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less intensive settings. However, spending on inpatient rehabilitation hospitals has increased since 2009.
- FFS spending on skilled nursing facilities increased sharply in 2011, reflecting providers' responses to the implementation of the new case-mix groups (resource utilization groups, version IV) beginning October 2010.

Chart 8-3. Since 2006, the share of Medicare stays and payments going to freestanding SNFs and for-profit SNFs has increased

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	2006	2010	2006	2010	2006	2010
All SNFs	100%	100%	100%	100%	100%	100%
Freestanding	92	94	89	93	94	96
Hospital based	8	6	11	7	6	4
Urban	67	70	79	81	81	83
Rural	33	30	21	19	19	17
For profit	68	70	67	70	73	74
Nonprofit	26	25	29	25	24	22
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding or missing information about facility characteristics.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files 2006–2010.

- Freestanding SNFs made up 94 percent of facilities in 2010.
- Freestanding SNFs treated 93 percent of stays (up 4 percentage points from 2006) and accounted for 96 percent of Medicare payments.
- For-profit facilities made up 70 percent of facilities in 2010. Between 2006 and 2010, for-profit SNFs' share of Medicare-covered stays increased 3 percentage points and payments increased 1 percentage point.
- Urban SNFs' share of facilities, Medicare-covered stays, and payments increased between 2006 and 2010.

Chart 8-4. Small declines in SNF days and admissions between 2009 and 2010

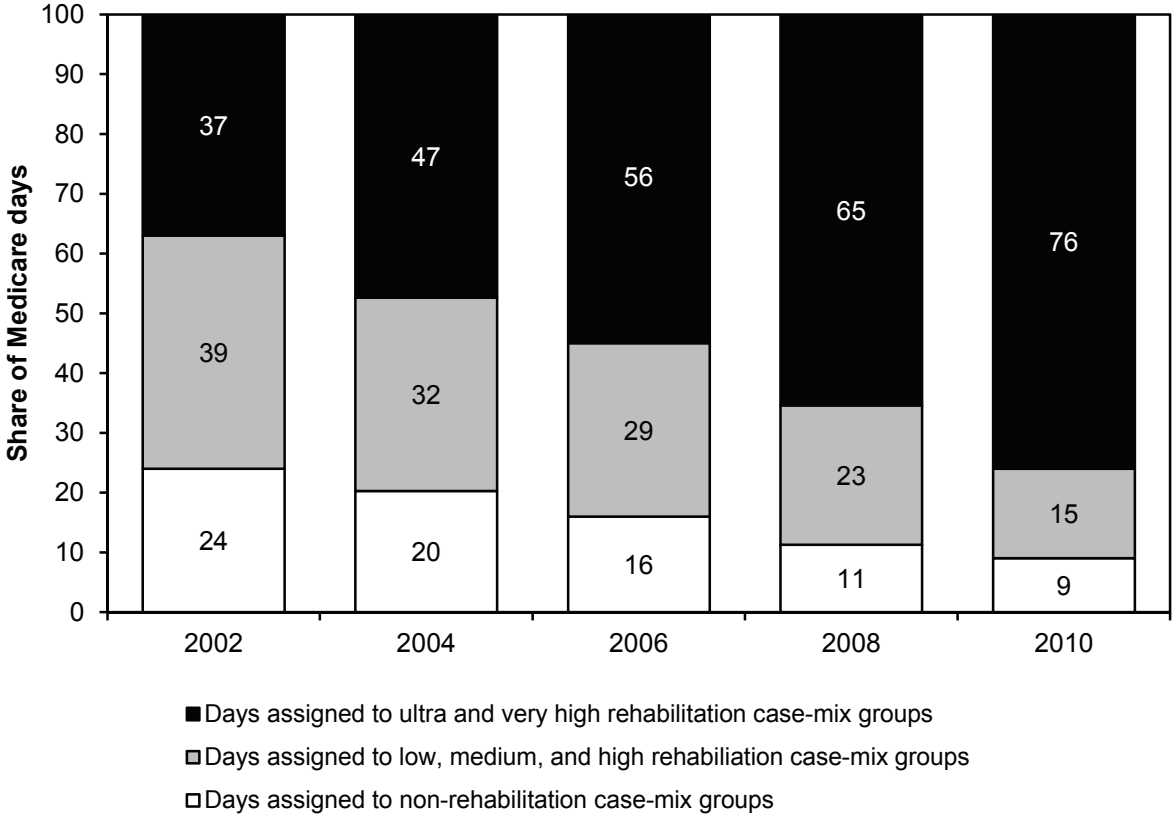
	2008	2009	2010	Change 2009–2010
Volume per 1,000 fee-for-service beneficiaries				
Covered admissions	73	72	71	–1.4%
Covered days	1,977	1,963	1,938	–1.3
Covered days per admission	27.0	27.3	27.1	–0.7

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Research, Development and Information.

- Between 2009 and 2010, covered days and admissions declined. The decline in admissions is expected because inpatient hospital stays, which are required for Medicare coverage of skilled nursing facility services, also declined. Despite the reductions, covered days and covered days per admission were higher than in 2006 (not shown).

Chart 8-5. Case mix in freestanding SNFs shifted toward highest rehabilitation case-mix groups and away from other categories



Note: SNF (skilled nursing facility). Days are for freestanding SNFs with valid cost reports. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of freestanding SNF cost reports.

- In 2010, rehabilitation resource utilization groups (RUGs) accounted for 91 percent of all Medicare days in SNFs. The two highest payment rehabilitation case-mix groups (ultra high and very high) made up 76 percent of all days (compared with 37 percent in 2002). Days not classified into a rehabilitation case-mix group declined from 24 percent in 2002 to 9 percent in 2010.

- Some of the growth in total rehabilitation days may be explained by a shift in the site of care from inpatient rehabilitation facilities to SNFs. It also could reflect the payment incentives to furnish the services necessary to get patients classified into higher paying rehabilitation RUGs.

Chart 8-6. Freestanding SNF Medicare margins have exceeded 10 percent for seven years, and have increased steadily since 2005

Type of SNF	2004	2005	2006	2007	2008	2009	2010
All	13.7%	13.1%	13.3%	14.7%	16.6%	18.0%	18.5%
Urban	13.2	12.6	13.1	14.5	16.3	17.9	18.5
Rural	16.1	15.2	14.3	15.5	18.0	18.7	18.4
For profit	16.1	15.2	15.7	17.2	19.1	20.2	20.7
Nonprofit	3.5	4.5	3.5	4.1	6.9	9.6	9.5
Government*	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility), N/A (not applicable).
*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports.

- Although aggregate Medicare margins for freestanding SNFs have varied over the past 7 years, they have exceeded 10 percent every year since 2001 (early years not shown).
- Aggregate Medicare margins increased from 2009 to 2010 due to costs per day growing more slowly than payments per day. The growth in payments reflected the increased share of days classified into the highest paying resource utilization groups.
- Examining the distribution of 2010 margins, one-half of freestanding SNFs had margins of 18.9 percent or more (not shown). One-quarter had Medicare margins at or below 9 percent and one-quarter had margins of 26.9 percent or higher.

Chart 8-7. Freestanding SNFs with relatively low costs and relatively high quality maintained high Medicare margins

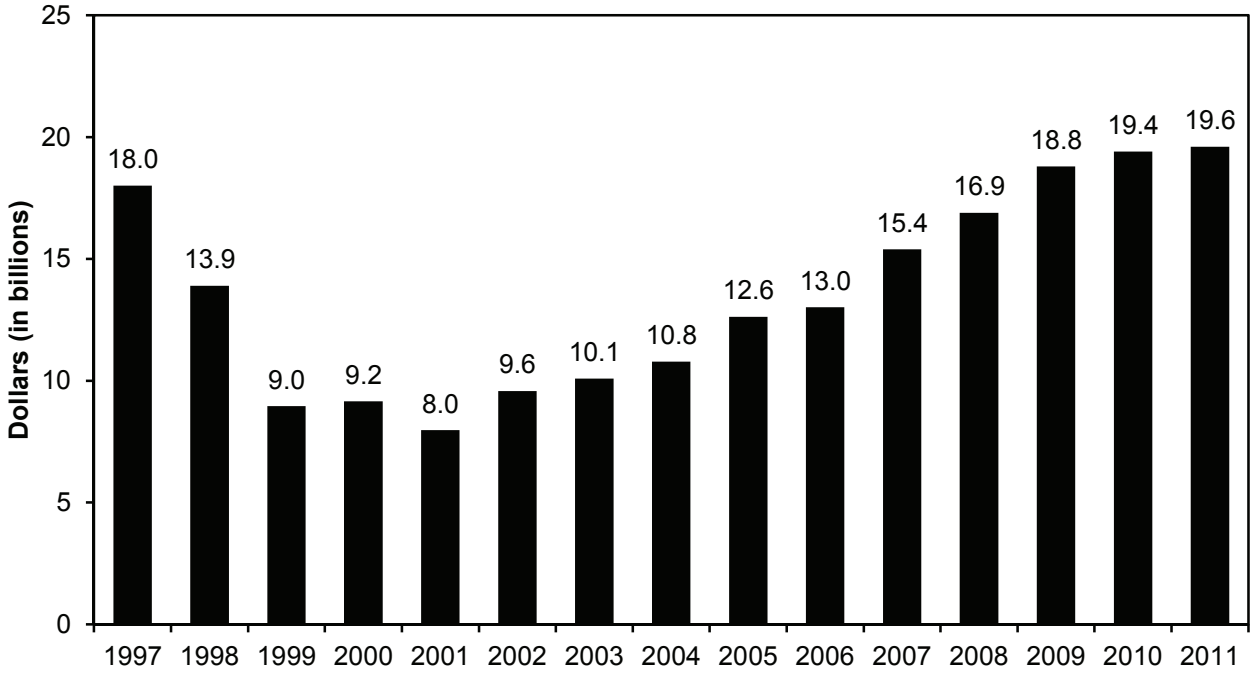
Characteristic	SNFs with relatively low costs and good quality (10 percent)	Other SNFs
Performance in 2009		
Relative* community discharge rate	1.38	0.95
Relative* rehospitalization rate	0.83	1.02
Relative* cost per day	0.90	1.02
Medicare margin	22.0%	18.2%
Performance in 2010		
Relative* cost per day	0.92	1.01
Medicare margin	22.0%	18.9%
Total margin	5.1	3.8
Medicaid share of facility days	59%	63%

Note: SNF (skilled nursing facility). SNFs with relatively low costs and good quality were those in the lowest third of the distribution of cost per day, in the top third for one quality measure, and not in the bottom third for the other quality measure. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Increases in rates of discharge to the community indicate improved quality; increases in rehospitalization rates for the five conditions indicate worsening quality. Quality measures were calculated for all facilities with more than 25 stays.
*Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2006–2009 and Medicare cost report data for 2006–2010.

- Freestanding SNFs can have relatively low costs and provide good quality of care while maintaining high margins.
- In 2009, compared with average SNFs, relatively efficient SNFs had community discharge rates that were 38 percent higher and rehospitalization rates that were 17 percent lower.
- In 2010, relatively efficient SNFs had costs per day that were 8 percent lower than average SNFs. Relatively efficient SNFs had median Medicare margins in 2010 of 22 percent compared with a median margin for other SNFs of 18.9 percent.
- Relatively efficient SNFs were more likely to be located in a rural area and more likely to be nonprofit than other SNFs (not shown).

Chart 8-8. Spending for home health care, 1997–2011



Source: CMS, Office of the Actuary, 2012.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period, and enforcing the program's standards became more difficult. Providers delivering billing for fraudulent or uncovered services were also a significant factor in the increase in expenditures.

- Spending began to fall after 1997, concurrent with the introduction of the interim payment system (IPS) based on costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.

- In October 2000, the prospective payment system (PPS) replaced the IPS. At the same time, eligibility for the benefit broadened slightly.

- Home health care has risen rapidly under PPS. Spending has risen by about 10 percent a year between 2001 and 2009, but growth slowed in 2010 and 2011.

Chart 8-9. Provision of home health care changed after the prospective payment system started

				Percent change	
	1997	2001	2010	1997–2001	2001–2010
Number of visits (in millions)	258	74	125	–71%	69%
Visit type (percent of total)					
Home health aide	48%	25%	16%		
Skilled nursing	41	50	52		
Therapy	10	24	33		
Medical social services	1	1	1		
Visits per home health patient	73	33	36	–55	9

Note: The prospective payment system began in October 2000. Totals may not sum to 100 percent due to rounding.

Source: Home health Standard Analytic File; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002.

- The types and amount of home health care services that beneficiaries receive have changed. In 1997, home health aide services were the most frequently provided visit type, and beneficiaries who used home health care received an average of 73 visits.

- CMS began to phase in the interim payment system in October 1997 to stem the rise in spending for home health services and implemented a prospective payment system (PPS) in 2000 (see Chart 8-8). By 2001, total visits dropped by 72 percent, and average visits per user had dropped to 33. The increase in visits per user between 2001 and 2010 reflects home health users getting more episodes. The mix of services changed as well, with skilled nursing and therapy visits now accounting for over 80 percent of all services. Since PPS was implemented, the number of users and episodes has risen rapidly (see Chart 8-10).

Chart 8-10. Trends in provision of home health care

	2002	2005	2010	Average annual percent change 2002–2010
Number of users (in millions)	2.5	3.0	3.4	3.9%
Percent of beneficiaries who used home health	7.2%	8.1%	9.6%	3.6
Episodes (in millions)	4.1	5.2	6.8	6.6
Episodes per home health patient	1.6	1.8	2.0	2.6
Visits per home health patient	31	32	36	2.2
Average payment per episode	$2,335	$2,465	$2,839	2.5

Source: MedPAC analysis of the home health Standard Analytic File.

- Under the prospective payment system, in effect since 2000, the number of users and the number of episodes have risen significantly. In 2010, 3.4 million beneficiaries used the home health benefit.
- The number of home health episodes increased rapidly from 2002 to 2010. The number of beneficiaries using home health has also increased since 2002, but at a lower rate than the growth in episodes.
- The number of visits per home health patient increased from 31 in 2002 to 36 in 2010. This increase is primarily due to a rise in the number of home health episodes per patient.

Chart 8-11. Margins for freestanding home health agencies

	2009	2010	Percent of agencies 2010
All	18.2%	19.4%	100%
Geography			
Mostly urban	18.5	19.4	86
Mostly rural	17.0	19.7	14
Type of control			
For profit	19.8	20.7	87
Nonprofit	13.0	15.3	13
Volume quintile			
First	8.9	9.9	20
Second	10.2	11.6	20
Third	14.9	13.9	20
Fourth	18.1	18.2	20
Fifth	20.3	22.1	20

Note: Agencies characterized as urban or rural based on the residence of the majority of their patients. Agencies with outlier payments that exceeded 10 percent of Medicare revenues are excluded from the reported statistics.

Source: MedPAC analysis of 2009–2010 Cost Report files.

- In 2010, about 80 percent of agencies had positive margins (not shown in chart). These estimated margins indicate that Medicare's payments are above the costs of providing services to Medicare beneficiaries for both rural and urban home health agencies (HHAs).
- These margins are for freestanding HHAs, which composed about 85 percent of all HHAs in 2010. HHAs are also based in hospitals and other facilities.
- HHAs that served mostly urban patients in 2010 had an aggregate average margin of 19.4 percent; those that served mostly rural patients had an aggregate average margin of 19.7 percent. The 2009 margin is consistent with the historically high margins the home health industry has experienced under the prospective payment system. The aggregate average margin from 2001 to 2009 averaged 17.5 percent, indicating that most agencies have been paid well in excess of their costs under prospective payment.
- For-profit agencies in 2010 had an aggregate average margin of 20.7 percent, and nonprofit agencies had an aggregate average margin of 15.3 percent.
- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2010 have an aggregate average margin of 9.9 percent, while those in the highest quintile have an aggregate average margin of 22.1 percent.

Chart 8-12. Most common types of inpatient rehabilitation facility cases, 2011

Type of case	Share of cases
Stroke	19.8%
Fracture of the lower extremity	13.9
Major joint replacement	10.5
Debility	10.4
Neurological disorders	10.3
Brain injury	7.5
Other orthopedic	7.0
Cardiac conditions	5.1
Spinal cord injury	4.3
Other	11.1

Note: Other includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS (January through June of 2011).

- In 2011, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing close to 20 percent of cases, up from 2004, when stroke represented fewer than 17 percent of cases.
- Major joint replacement cases represented close to 11 percent of IRF admissions in 2011, down from 24 percent of cases in 2004, when major joint replacement was the most common IRF Medicare case type.

Chart 8-13. Volume of IRF FFS patients declined slightly in 2010

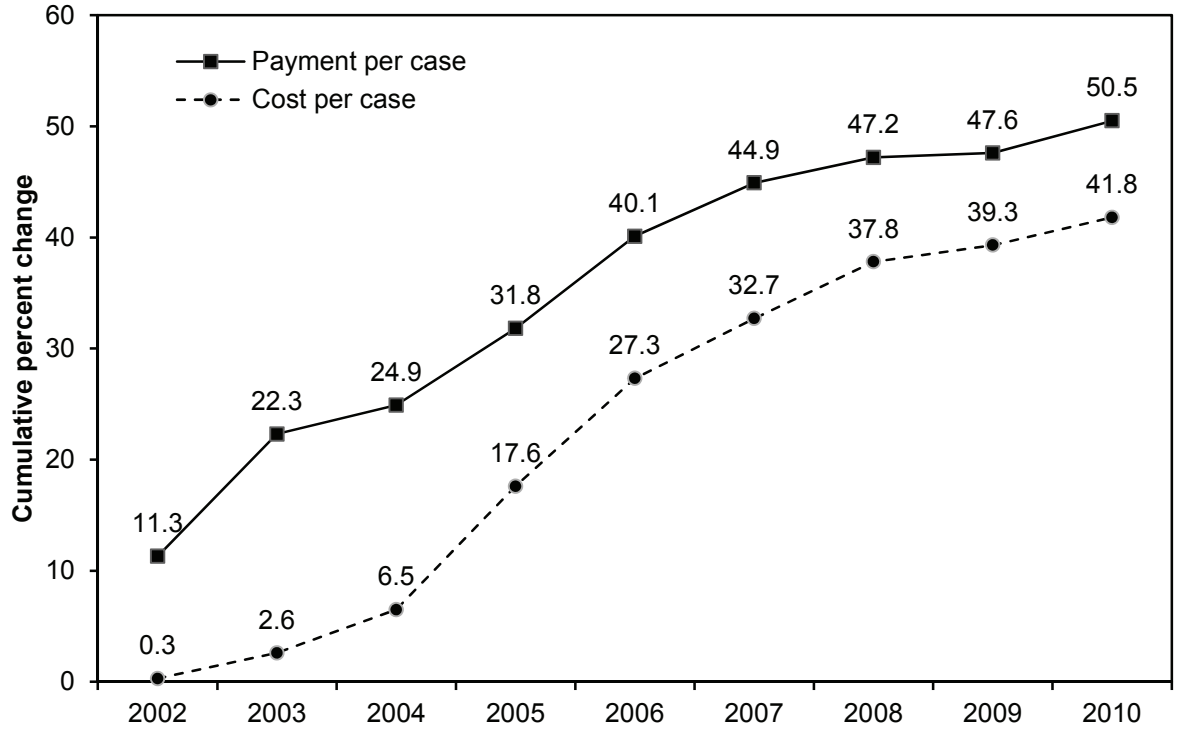
	2004	2008	2009	2010	Average annual percent change 2004–2009	Percent change 2009–2010
Number of IRF cases	495,000	356,000	364,000	359,000	–6.2%	–1.3%
Unique patients per 10,000 FFS beneficiaries	123.0	91.5	93.0	91.1	–5.8	–2.1
Payment per case	$13,290	$16,646	$16,552	$17,085	5.2	3.2
Medicare spending (in billions)	$6.43	$5.95	$6.03	$6.32	–0.3	4.8
Average length of stay (in days)	12.7	13.3	13.1	13.1	0.6	0

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Numbers of cases reflect Medicare FFS utilization only.

Source: MedPAC analysis of MedPAR data from CMS. Total Medicare spending for IRF services from CMS Office of the Actuary.

- IRF volume is measured by the number of IRF cases and the number of unique patients per 10,000 beneficiaries, which controls for changes in FFS enrollment.
- IRF volume declined after 2004 when enforcement of the compliance threshold (60 percent rule) was renewed.
- Medicare FFS spending on IRFs declined between 2004 and 2008 as more IRFs complied with the 60 percent rule and more Medicare beneficiaries enrolled in Medicare Advantage plans.
- The number of IRF cases increased between 2008 and 2009. This increase was due to an increase in both the number of unique beneficiaries receiving IRF care and an increase in the number of beneficiaries with more than one IRF stay in a year.
- In 2010, the number of IRF cases declined slightly by 1.3 percent. This decline may in part be due to the revised coverage criteria for an IRF stay that went into effect in January 2010. The revised coverage criteria did not change, but more clearly defined, which Medicare beneficiaries are appropriate for IRFs. Therefore, some patients that IRFs would have admitted previously might not have met the more specific coverage criteria in 2010.

Chart 8-14. Overall IRFs' payments per case have risen faster than costs since implementation of the PPS in 2002



Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system). Data are from consistent two-year cohorts of IRFs. Costs are not adjusted for changes in case mix.

Source: MedPAC analysis of cost report data from CMS.

- Since implementation of the PPS in 2002, overall Medicare payments per case have increased faster than costs, even when costs per case grew rapidly between 2004 and 2006 as a result of enforcement of the compliance threshold.

- These trends in Medicare per case payments and costs are reflected in IRFs' Medicare margins, shown in Chart 8-15.

Chart 8-15. Inpatient rehabilitation facilities' Medicare margin by type, 2002–2010

	2002	2004	2006	2008	2009	2010
All IRFs	10.8%	16.7%	12.4%	9.5%	8.4%	8.8%
Hospital based	6.1	12.2	9.7	4.1	0.4	-0.2
Freestanding	18.5	24.7	17.5	18.2	20.3	21.4
Urban	11.3	16.9	12.6	9.7	8.6	9.1
Rural	5.9	13.9	10.6	7.6	6.3	5.5
Nonprofit	6.5	12.8	10.7	5.6	2.3	2.0
For profit	18.5	24.4	16.3	16.7	19.0	19.8

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of cost report data from CMS.

- The aggregate Medicare margin increased rapidly during the first two years (2002–2004) of the IRF prospective payment system (PPS). Aggregate margins rose from just under 2 percent in 2001 to almost 17 percent in 2004.
- From 2004 to 2009, margins declined, but remained high. This decline was largely due to reductions in patient volume over this time period that resulted in fewer patients among whom to distribute fixed costs. The 2007 to 2009 margin decrease was mainly a result of a zero update to the base rates for half of 2008 and for all of 2009 that resulted in Medicare payment rates remaining at 2007 levels.
- Margins increased in 2010 from 8.4 percent in 2009 to 8.8 percent in 2010.
- Freestanding and for-profit IRFs had substantially higher aggregate Medicare margins than hospital-based and nonprofit IRFs, continuing a trend that began with implementation of the IRF PPS in 2002.

Chart 8-16. The top 25 MS–LTC–DRGs made up nearly two-thirds of LTCH discharges in 2010

MS-LTC DRG	Description	Discharges	Percentage	Change 2008-2010
207	Respiratory system diagnosis with ventilator support 96+ hours	16,024	11.9%	6.9%
189	Pulmonary edema and respiratory failure	11,148	8.3	27.5
871	Septicemia or severe sepsis without ventilator support 96+ hours with MCC	7,474	5.5	15.3
177	Respiratory infections & inflammations with MCC	5,067	3.8	16.8
592	Skin ulcers with MCC	3,568	2.6	–10.9
949	Aftercare with CC/MCC	3,046	2.3	–18.8
208	Respiratory system diagnosis with ventilator support <96 hours	2,851	2.1	14.7
193	Simple pneumonia and pleurisy with MCC	2,847	2.1	5.6
190	Chronic obstructive pulmonary disease with MCC	2,654	2.0	3.8
539	Osteomyelitis with MCC	2,415	1.8	26.9
573	Skin graft and/or debridement for skin ulcer or cellulitis with MCC	2,059	1.5	7.7
862	Postoperative and post-traumatic infections with MCC	2,033	1.5	21.6
314	Other circulatory system diagnosis with MCC	1,983	1.5	33.4
919	Complications of treatment with MCC	1,950	1.4	17.5
682	Renal failure with MCC	1,937	1.4	11.4
166	Other respiratory system OR procedures with MCC	1,911	1.4	12.9
559	Aftercare, musculoskeletal system and connective tissue with MCC	1,877	1.4	–3.4
291	Heart failure and shock with MCC	1,821	1.4	7.9
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,656	1.2	17.1
593	Skin ulcers with CC	1,646	1.2	–36.4
178	Respiratory infections and inflammations with CC	1,644	1.2	–16.3
602	Cellulitis with MCC	1,593	1.2	40.0
870	Septicemia or severe sepsis with ventilator support 96+ hours	1,592	1.2	47.7
603	Cellulitis without MCC	1,432	1.1	2.3
194	Simple pneumonia and pleurisy with CC	1,285	1.0	–22.3
	Top 25 MS–LTC–DRGs	83,513	62.0	8.5
	Total	134,683	100.0	2.9

Note: MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS–LTC–DRGs are the case-mix system for LTCHs.
Columns may not sum due to rounding.

Source: MedPAC analysis of MedPAR data from CMS.

- Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2010, the top 25 MS–LTC–DRGs accounted for nearly two-thirds of all cases.
- The most frequent diagnosis in LTCHs in 2010 was respiratory system diagnosis with ventilator support for more than 96 hours. Ten of the top 25 diagnoses, representing 35 percent of all cases, were respiratory conditions.

Chart 8-17. LTCH spending per FFS beneficiary continues to rise

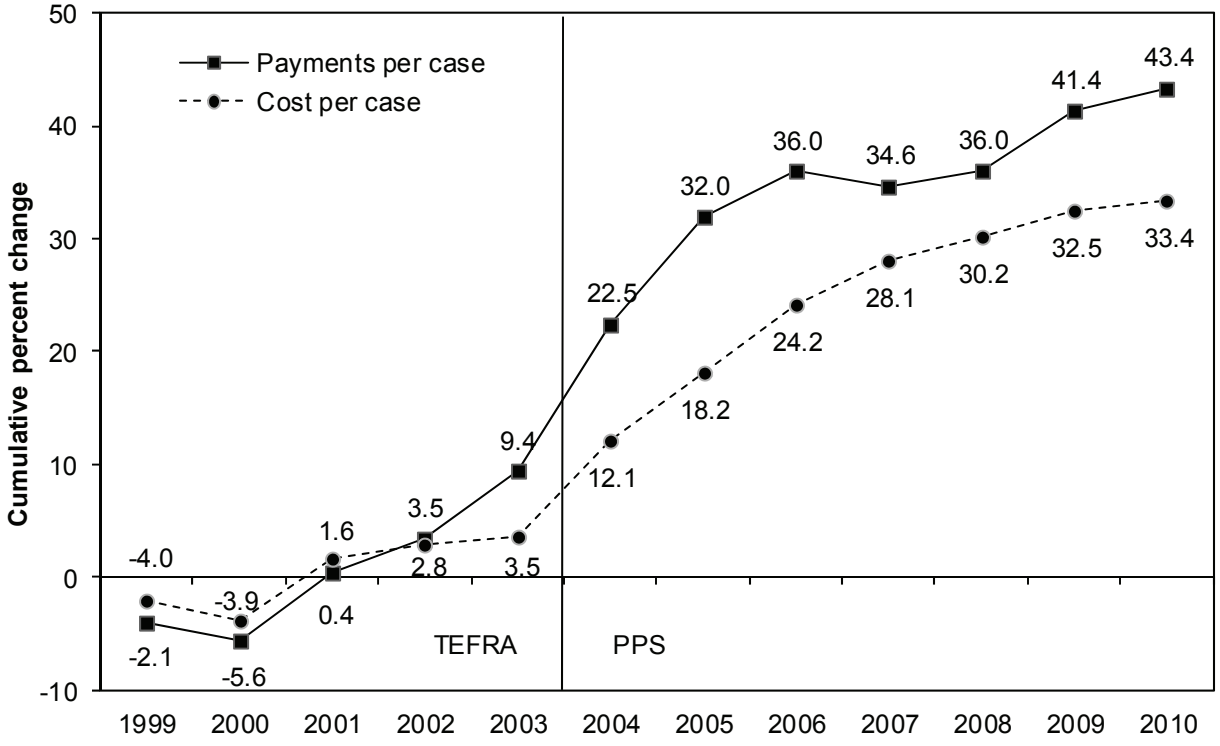
	2003	2004	2005	2006	2007	2008	2009	2010	Average annual change 2003–2005	Average annual change 2005–2009	Average annual change 2009–2010
Cases	110,396	121,955	134,003	130,164	129,202	130,869	131,446	134,683	10.2%	-0.5%	2.5%
Cases per 10,000 FFS beneficiaries	30.8	33.4	36.4	36.0	36.3	37.0	37.1	38.4	8.8	0.5	3.5
Spending (in billions)	$2.7	$3.7	$4.5	$4.5	$4.5	$4.6	$4.9	$5.2	29.1	2.2	6.0
Spending per FFS beneficiary	$75.2	$101.3	$122.2	$124.3	$126.5	$130.2	$138.3	$148.1	27.5	3.1	7.1
Payment per case	$24,758	$30,059	$33,658	$34,859	$34,769	$35,200	$37,465	$38,582	16.6	2.7	3.0
Length of stay (in days)	28.8	28.5	28.2	27.9	26.9	26.7	26.4	26.6	–1.0	–1.6	0.8

Note: LTCH (Long-term care hospital), FFS (fee for service)

Source: MedPAC analysis of MedPAR data from CMS.

- Between 2009 and 2010, the number of LTCH cases per FFS beneficiary rose 3.5 percent. Medicare LTCH spending per fee-for-service beneficiary rose more than twice as much over the same period (7.1 percent).

Chart 8-18. LTCHs' per case payments rose more quickly than costs in 2010



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Payment per case increased rapidly after the PPS was implemented, climbing an average 16.6 percent per year between 2003 and 2005. Cost per case also increased rapidly during this period, albeit at a somewhat slower pace.

- Between 2005 and 2008, growth in cost per case outpaced that for payments, as regulatory changes to Medicare's payment policies for LTCHs slowed growth in payment per case to an average of 1.4 percent per year.

- After the Congress delayed implementation of some of CMS's recent regulations, payments per case climbed 5.3 percent between 2008 and 2009, about twice as much as the growth in costs. However, between 2009 and 2010, payment growth slowed to 2 percent, while cost growth was held under 1 percent.

Chart 8-19. LTCHs' aggregate Medicare margin rose in 2010

Type of LTCH	Share of discharges	2003	2004	2005	2006	2007	2008	2009	2010
All	100%	5.2%	9.0%	11.9%	9.8%	4.8%	3.5%	5.6%	6.4%
Urban	96	5.2	9.2	11.9	10.0	5.1	3.8	5.9	6.7
Rural	5	4.5	2.6	10.1	4.9	–0.7	–3.3	–2.8	–0.5
Freestanding	70	5.6	8.4	11.3	9.3	4.4	3.1	4.7	5.6
Hospital within hospital	30	4.2	10.6	13.1	10.8	5.8	4.4	7.6	8.1
Nonprofit	16	1.7	6.9	9.1	6.4	1.3	–2.5	–0.6	–1.2
For profit	83	6.3	10.0	13.1	10.9	5.9	5.1	7.2	8.0
Government	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not available). Share of discharges column groupings may not sum to 100 percent due to rounding or missing data. Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of cost report data from CMS.

- After implementation of the prospective payment system, LTCHs' Medicare margins increased rapidly, from 5.2 percent in 2003 to 11.9 percent in 2005. Margins then fell as growth in payments per case leveled off. In 2009, however, LTCH margins began to increase again, reaching 6.4 percent in 2010.

- Financial performance in 2010 varied across LTCHs. Margins increased between 2009 and 2010 for all types of LTCHs except nonprofits, whose margins fell from –0.6 percent to –1.2 percent. The aggregate Medicare margin for for-profit LTCHs (which accounted for 83 percent of all Medicare discharges from LTCHs) was 8.0 percent. Rural LTCHs' aggregate margin was –0.5 percent, compared with 6.7 percent for their urban counterparts. Rural providers account for about 5 percent of LTCHs discharges, caring for a smaller volume of patients on average, which may result in poorer economies of scale.

Chart 8-20. LTCHs in the top quartile of Medicare margins in 2010 had much lower costs

Characteristics	High-margin quartile	Low-margin quartile
Mean Medicare margin	20.9%	–11.3%
Mean total discharges (all payers)	576	444
Medicare patient share	68%	64%
Medicaid patient share	8	5
Occupancy rate	74	62
Average length of stay (in days)	26	27
Adjusted CMI	0.9743	0.8981
Mean per discharge:		
Standardized costs	$26,660	$36,251
Total Medicare payment*	$38,557	$38,157
High-cost outlier payments	$1,316	$5,005
Share of:		
Cases that are SSOs	26%	34%
Medicare cases from primary-referring ACH	35	41
LTCHs that are for-profit	90	64

Note: LTCH (long-term care hospital), CMI (case-mix index), SSO (short-stay outlier), ACH (acute care hospital). Includes only established LTCHs—those that filed valid cost reports in both 2009 and 2010. Top margin quartile LTCHs were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. Adjusted case-mix indices have been adjusted for differences in SSOs across facilities. Average primary referring ACH referral share indicates the mean share of patients referred to LTCHs in the quartile from the ACH that refers the most patients to the LTCH. Government providers were excluded.
*Includes outlier payments.

Source: MedPAC analysis of LTCH cost reports and MedPAR data from CMS.

- A quarter of all LTCHs had margins in excess of 20.9 percent, while another quarter had margins below –11.3 percent.

- Lower per discharge costs, rather than higher payments, drove the differences in financial performance between LTCHs with the lowest and highest Medicare margins. Low-margin LTCHs had standardized costs per discharge that were 36 percent higher than high-margin LTCHs ($36,251 vs. $26,660). Low-margin LTCHs served more patients overall and had a lower average occupancy rate; thus, they benefit less from economies of scale.

- High-cost outlier payments per discharge for low-margin LTCHs were almost four times those of high-margin LTCHs ($5,005 vs. $1,316). At the same time, SSOs made up a larger share of low-margin LTCHs' cases. Low-margin LTCHs thus cared for disproportionate shares of patients who are high-cost outliers and patients who have shorter stays.

Web links. Post-acute care

Skilled nursing facilities

- Chapter 7 of MedPAC's March 2012 Report to the Congress provides information about the supply, quality, service use, and Medicare margins for skilled nursing facilities. Chapter 7 of MedPAC's June 2008 Report to the Congress provides information about alternative designs for Medicare's prospective payment system that would more accurately pay providers for their skilled nursing facility services. *Medicare payment basics: Skilled nursing facility payment system* provides a description of how Medicare pays for skilled nursing facility care.

  http://www.medpac.gov/chapters/Mar12_Ch07.pdf

  http://www.medpac.gov/chapters/Jun08_Ch07.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_SNF.pdf

- The official Medicare website provides information on skilled nursing facilities, including the payment system and other related issues.

  http://www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPPS/

Home health services

- Chapter 8 of MedPAC's March 2012 Report to the Congress provide information on home health services. *Medicare payment basics: Home health care services payment system* provides a description of how Medicare pays for home health care.

  http://www.medpac.gov/chapters/Mar12_Ch08.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_HHA.pdf

- The official Medicare website provides information on the quality of home health care and additional information on new policies, statistics, and research as well as information on home health spending and use of services.

  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

Inpatient rehabilitation facilities

- Chapter 9 of MedPAC's March 2011 Report to the Congress provides information on inpatient rehabilitation facilities. *Medicare payment basics: Rehabilitation facilities (inpatient) payment system* provides a description of how Medicare pays for inpatient rehabilitation facility services.

  http://www.medpac.gov/chapters/Mar12_Ch09.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_IRF.pdf

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://www.cms.gov/medicare/medicare-fee-for-service-payment/InpatientRehabFacPPS/

Long-term care hospitals

- Chapter 10 of MedPAC's March 2011 Report to the Congress provides information on long-term care hospitals. *Medicare payment basics: Long-term care hospital services payment system* provides a description of how Medicare pays for long-term care hospital services.

  http://www.medpac.gov/chapters/Mar12_Ch10.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_LTCH.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://www.cms.gov//medicare/medicare-fee-for-service-payment/LongTermCareHospitalPPS/